STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085037	A. BUILDING _____ B. WING _____	C 05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLANTIC SHORES REHABILITATION & HEALTH CENTER	231 SOUTH WASHINGTON STREET MILLSBORO, DE 19966

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from May 8, 2012 through May 10, 2012. The deficiencies cited in this report are based on observations, record review and staff interviews. The census the first day of the survey was 174. The sample size included six (6) active records and two (2) closed records.	F 000	The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable law. The facility has achieved substantial compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	F225 1. Resident R3 currently resides in the facility and has made no further allegations of sexual and/or physical abuse. 2. An audit was conducted on incident/accident reports and complaints 30 days prior to date of survey exit to present, to ensure timely reporting to the state. Any issues identified for timely reporting was reported to the state immediately and an investigation was conducted as appropriate.	6/22/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 5/24/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documents including their policy and procedures it was determined that the facility failed to report to the state agency in a timely manner an allegation of sexual abuse for one (R3) out of 8 sampled residents. Findings include: Review of R3's medical record revealed she had diagnoses that included dementia with delusional features, depression, psychosis, insomnia due to mental disorder, multiple sclerosis and hypertension. R3's nurses notes documented on 12/11/11 at 10:30 AM that R3 "Made comments that she had been sexually touched by CNA". The 12/12/11 9:30 AM R3's nursing notes documented "Resident sitting at nurses station making accusatory/delusional statements...staff members sexually touching her and trying to kill her" After contacting the E2 (DON), nurse practitioner and the family it was decided to send R3 to the emergency room for medical clearance	F 225	3. All staff was re-education on requirement of timely reporting to the state. Nursing management and department heads also received education on contacting Administrator and/or DON/ADON on weekends and after hours of reportable incidents. 4. Incidents/Accidents and concerns are reviewed M-F in the AM meeting. Information regarding any reportable event is aggregated and reported at the monthly QI meeting by the ADON or designee.	

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F 225	Continued From page 2 before sending her to Meadow Wood. When R3 was in the emergency room she reported to the staff that "5 women were in her room last night and raped her like a man would." The hospital performed an exam on R3. The hospital documentation indicated there was no evidence of trauma or sexual abuse to R3. Review of the facility's incident report and investigation of R3's allegation of sexual abuse revealed the facility began their investigation on 12/12/11. The report lacked evidence that an investigation was started on 12/11/11 when the nurses notes documented the first allegation of sexual abuse. Review of the state reporting system revealed the facility failed to notify the state agency of the allegations of sexual abuse documented in the nurses notes on 12/11/11 and 12/12/11. However, on 12/19/11 the facility sent a 5-day follow up of the incident to the state agency (8 days after the allegation of sexual abuse was documented). The facility's policy and procedures for "Abuse Prohibition" stated "III Reporting: *The Division of Long Term Care Resident protection (DLTCRP) will be immediately notified of all allegations of abuse, mistreatment, neglect, and misappropriation of resident property." An interview conducted with E2 (ADON) on 5/9/12 at 10:30 AM confirmed the facility should have started an investigation on R3's allegation of sexual abuse on 12/11/11 instead of waiting until	F 225		

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F 225	Continued From page 3 the second allegation was made on 12/12/11. E2 continued to confirm that the facility was late in reporting the above mentioned allegations of sexual abuse. The facility should have sent an initial incident report to the state agency on 12/11/11 when the allegation of sexual abuse was made.	F 225		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews, it was determined that the facility failed to provide adequate supervision and failed to ensure all interventions were working properly for one (R2) out of 8 sampled residents to prevent R2 from eloping from the facility. Findings include: Review of R2's clinical records revealed R2 was admitted to the facility on 4/7/11 with diagnoses that included mild mental retardation, post ORIF (open reduction internal fixation) of right tibia and fibula secondary to MVA (motor vehicle accident) which also resulted in fractures of his left ribs, distal radius, ulna, frontal sinus and orbital floor. Review of R2's discharge history and physical dated 9/21/11 revealed that he was a pedestrian	F 323	F 323 1. R2 no longer resides in the facility, therefore no corrective action can be taken for R2. 2. All residents assessed as elopement risks have the potential to be affected. All residents are assessed for elopement at the time of admission and at a minimum of quarterly. A facility wide audit was conducted to ensure all residents have been assessed appropriately for elopement risk and interventions implemented as appropriate. 3. A.The front door entrance/exit (inside door) is equipped with a coded electronic key pad requiring a special code to exit the facility coupled with a functioning wanderguard monitor that alarms when	6/22/12

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F 323	Continued From page 4 struck by a car that resulted in these fractures. On 4/7/11 and 5/2/11 an elopement risk assessment documented that R2 was an "elopement risk one or more factors". On 7/18/11 R2 had another elopement assessment completed that indicated R2 had "no elopement risk: no risk factors". Review of R2's quarterly MDS assessment dated 7/15/11 section E0300 documented R2 displayed wandering behaviors 1-3 days. Review of R2's interim care plan dated on 4/8/11 documented under behavior problem that R2 wanted to go home. As an intervention/approach the facility documented a wanderguard (an alarm devise to deter resident elopement) placement was implemented. On 7/18/11 R2 had a care plan for Elopement with a goal: will not successfully elope the facility and will be monitored of his whereabouts on an ongoing basis. The approaches/interventions included: - use audible monitoring system to alert staff of exit seeking behaviors -check for proper functioning of the audible alarm system every shift and prn (as needed) R2 's nursing note dated 9/11/11 at 11:15 AM documented that E6 (LPN) received a phone call at approximately 10:30 AM from R2's sister alerting her that a neighbor saw R2 at the gas station/convenience store. (This store was located at the corner of the intersections of state highway Route 113 and Route 24. The convenience store was across the street from the facility. State Route113 had 4 lanes and Route 24 had 2 lanes with traffic lights.) E6 contacted the	F 323	triggered by a worn wanderguard device prior to exit. Additionally, a surveillance camera has been added at this exit. B. All emergency exit doors are controlled by key pads, instant armed key controlled alarms and surveillance cameras. This includes the emergency exit door located on Station 3 hallway next to room #520. C. The kitchen exit door (to the loading dock has been secured with a coded mechanical door lock and is also covered by a surveillance camera. 4. Door alarms, key pads, wanderguard system and surveillance camera system are checked and monitored weekly. All residents assessed as elopement risks are reviewed by Unit Managers on-going and weekly. An elopement photo panel of all elopement risk residents is reviewed, updated and placed on all units and at the front receptionist desk on-going and weekly. Newly assessed residents are added to the list as identified.	

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F 323	Continued From page 5 supervisor and while she was searching the building, R2 was returned to the facility. An assessment was performed and no injury was noted. The wanderguard was also checked and was in working condition. Incident reports were completed with notifications noted on 9/11/11. Review of R2's incident reports revealed E6 noted in her statement that the door R2 exited from had a keypad system but it did not have an audible alarm to alert staff. E4 (maintenance director) came to the facility on 9/11/11 to secure the door with an alarm. E4 documented in his statement that the door was located behind the backdoor entrance of the kitchen. He installed a new keypad code, placed an instant audible alarm (key access not code) on the door and a sign with the phrase "alarm will sound". An inspection of all exit doors on the main floor was conducted with E1 (administrator) and E4 on 5/10/12 at 11:45 AM. E4 revealed that all doors have cameras and he was in the process of replacing the all instant door alarms to "key access". The surveyor was wearing a wanderguard during the inspection. The inspection of the doors with E1 and E4 revealed the following: 1. The wanderguard alarm system on the inside of front entrance doors (must walk through 2 doors before one can exit outside to the sidewalk/driveway) alarmed when the surveyor had exited the first door and was in the process of exiting the second door to the side walk. 2. The emergency exit door (with a battery operated code alarm) located in the station three hall way next to room 520 alarmed when the door	F 323		

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F 323	Continued From page 6 was opened and stopped sounding when the door closed without having E4 deactivate the alarm. 3. The kitchen exit door (to the loading dock area) had no keypad lock or door alarm to deter elopement. E1 confirmed the above findings. E4 immediately replaced the station three door alarm.	F 323		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Atlantic Shores Rehab and Health Center **DATE SURVEY COMPLETED:** May 10, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from May 8, 2012 through May 10, 2012. The deficiencies cited in this report are based on observations, record review and staff interviews. The census the first day of the survey was 174. The sample size included seven (7) active records and two (2) closed records.	The filing of this plan of correction does not constitute any admission as to any of the violations set forth in the statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance with all applicable law. The facility has achieved substantial compliance with all requirements as of the completion date specified in the plan of correction for the noted deficiency. Therefore, the facility requests that this plan of correction serve as its allegation of substantial compliance with all requirements
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS report date completed 5/10/12, F225 & F323.	Cross refer to the CMS Report 2567 Survey Report date completed 05/10/12, F225 & F323 6/22/12

Provider's Signature [signature] Title Administrator Date 5/24/12